DOCUMENT RESUME

ED 404 947 HE 029 963

TITLE	Medical Education and Research Costs (MERC). Study Recommendations and Progress Report to the Legislature.
INSTITUTION	Minnesota State Dept. of Health, St. Paul.
REPORT NO	MDH.HPSC.HEP
PUB DATE	Dec 96
NOTE	35p.; For related documents, see HE 029 960 and HE 029 962.
AVAILABLE FROM	Minnesota Department of Health, Health Economics Program, 121 East Seventh Place, P.O. Box 64975, St. Paul, MN 55164-0975.
PUB TYPE	Viewpoints (Opinion/Position Papers, Essays, etc.) (120)
EDRS PRICE	MF01/PC02 Plus Postage.
DESCRIPTORS	*Costs; *Financial Support; Health Personnel; Higher Education; *Medical Education; *Medical Research; Physicians; Program Descriptions; *Public Policy; State Legislation; State Programs; Statewide Planning
IDENTIFIERS	Health Care Reform; *Minnesota

ABSTRACT

This report discusses the activities of Minnesota's Medical Education and Research Costs (MERC) project, which was undertaken to gather data on the costs of medical education and health care research conducted by hospitals, medical centers, and health maintenance organizations and to develop mechanisms to assess the costs across the health care system. It provides a summary of the project's activities from 1993 through 1996, anticipated work for 1997, and recommendations for the funding of medical education and research in Minnesota. The report calls for: (1) the creation of a MERC Trust Fund to be financed by general fund and Health Care Access Fund dollars; (2) the shifting of medical education "add-on" funds from the Pre-Paid Medical Assistance Program to the MERC Trust Fund; (3) the accreditation of all programs seeking funds from the MERC Trust Fund; (4) the immediate implementation of legislation regarding distribution formulas; (5) the direction of funds to sponsoring institutions or consortia; (6) the implementation of specific application requirements for funding; and (7) the implementation of specific MERC annual cost and program report requirements. Appendixes provide additional information on MERC legislation and the MERC Advisory Committee members. (MDM)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

HE

ED 404 947

Medical Education and Research Costs (MERC)

Study Recommendations and Progress Report to the Legislature

December 1996

HE 0291 463

Minnesota Department of Health
Health Economics Program

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it

☐ Minor changes have been made to improve reproduction quality

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Minnesota Department of Health

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Medical Education and Research Costs (MERC)

Study Recommendations and Progress Report to the Legislature

For more information contact:

Denese McAfee
Health Economics Program
Health Policy and Systems Compliance Division
Minnesota Department of Health
P.O. Box 64975
St. Paul, Minnesota 55164-0975

Phone: (612) 282-6349
Fax: (612) 282-5628

As required by Minnesota Statute 3.197: This report cost approximately $3000 to prepare including staff time, printing and mailing expenses.

TABLE OF CONTENTS

Executive Summary 2

Introduction 6

Summary of Legislative History and Project Progress (1993-1996) . 6

Anticipated Work Plan for 1997 9

Revenue/Financing Subcommittee Report to the Commissioner . . 9

Eligibility/Reporting Subcommittee Report to the Commissioner . 13

Recommendations 19

Appendix A: MERC Legislation 21

Appendix B: MERC Advisory Committee Members 29

Medical Education and Research Costs (MERC) Study Recommendations and Project Progress (1993-1996)

Executive Summary

The Medical Education and Research Costs (MERC) project has continued to move forward under the direction of the Minnesota Legislature and the Commissioner of Health. The MERC Advisory Task Force, which represents key stakeholders, transitioned to the newly-created MERC Advisory Committee in 1996, and has assisted the commissioner since its inception in 1993. The Task Force has provided an overview of the problems and challenges associated with the funding of medical education and research in this state. In doing so, a preliminary estimate of the costs of medical education was developed. While the numbers are still considered only a preliminary estimate and focused only on medical education, the estimate did indicate a need for supplementary funding to maintain the current level of activities associated with medical education.

The legislature recognizes the importance of medical education and research to the state and its economy. Therefore, based upon the recommendations made in the February 1996 report, "Medical Education and Research Costs (MERC): A final report to the Legislature," the 1996 Minnesota Legislature established a Medical Education and Research Trust Fund. Although established, the Trust Fund was not funded and the "MERC Study" (1996 Minn. Laws 451; see Appendix A) was mandated to provide recommendations on the most appropriate option for one or more funding sources.

The MERC Study required the MERC Advisory Committee to "make recommendations to the commissioner of health...on potential sources of funding for medical education and research and on mechanisms for the distribution of such funding sources." Those recommendations are the primary focus of this report. A secondary focus of this report is to provide a progress report on the MERC project which was also required under 1996 Minn. Laws 451. That legislation requires a progress report to be submitted to the legislature by February 15th of each year.

The recommendations of the MERC Advisory Committee are to accept the current MERC legislation (see Appendix A, 1996 Minn. Laws 451), as written with minor changes. All of the recommendations presented in this section are based upon that legislation. The Commissioner of Health accepted all of the MERC Advisory Committee's recommendations on the mechanisms for distribution for the Trust Fund. However, the Advisory Committee's recommendations for a primary funding source for the Trust Fund were modified by the Commissioner of Health. The commissioner's recommendations to the legislature are presented for consideration as follows:

Recommendations on Potential Funding Sources:

The commissioner met with the MERC Advisory Committee to participate in their discussion of a recommendation for a funding source for the Trust Fund. The commissioner acknowledged that the Advisory Committee is opposed to use of the Health Care Access Fund (HCAF) for the reasons stated in their subcommittee report, and that if possible, she would support their recommendations, contingent on what appeared most feasible at the time of the release of the report. After further consideration, the commissioner deemed it necessary to modifiy Recommendation 1.

A detailed discussion of the rationale behind each of the recommendations is included in the MERC subcommittee reports to the commissioner, which are included later in this report. As noted previously, the commissioner has accepted all of the Advisory Committee's recommendations, without modification, except for Recommendation 1. The Advisory Committee recommended *only* the use of the General Fund. The commissioner has, however, modified that recommendation to include the HCAF. While the rationale for use of the General Fund is included in the Revenue/Financing Subcommittee Report, the commissioner's rationale for the inclusion of the HCAF as an additional source follows the recommendation.

Recommendation 1: ***The MERC Trust Fund should be financed by a combination of General Fund and Health Care Access Fund (HCAF) dollars.***[1]

Rationale for HCAF recommendation: The inclusion of the HCAF for consideration as a possible funding source is based on the fact that the fund is adequate, stable, and appropriate. The fund contains adequate funds to meet the request for funding of this project. Further, it is a stable source of funding, unlike the General Fund which projects structural deficits in the future. Finally, the HCAF is also an appropriate source as it is redistributing money collected *from* health care *for* health care-related activities. There is also a precedent for the use of the HCAF for medical education since the University of Minnesota receives funding from that source for the Primary Care Training Initiatives program. The most recent appropriation for that program was approximately $2.6 million.

Recommendation 2: ***Direct the medical education "add-on" funds from the Pre-Paid Medical Assistance Program (PMAP) to the Medical Education and Research Trust Fund for distribution.***

---

[1]The MERC Advisory Committee recommended to the Commissioner of Health that the most appropriate, stable, adequate and broad-based source of primary funding for the Medical Education and Research Trust Fund is the General Fund.

Recommendations on Mechanisms For Distribution:

Recommendation 3: ***All programs for which application is being made to the Medical Education and Research Trust Fund must already be accredited by an appropriate accreditation body at the time of application.***

Recommendation 4: ***The 1996 MERC legislation regarding the formula for distribution should be implemented as written without further incentives or factors being added at this time. The basic formula then becomes the average clinical cost per trainee (by provider type), multiplied by the number of trainees in each program, multiplied by a uniform percentage of costs with total disbursement equaling the amount available for education in the Trust Fund for that year.***

Recommendation 5: ***Funding from the Medical Education and Research Trust Fund should be directed to the sponsoring institution or consortium responsible for the accredited program(s) that incur the cost of training. The dollars will then be used to support the designated programs and affiliated sites.***

Recommendation 6: ***The 1996 MERC legislation regarding the application requirements (see Subd. 2, Section c below) should be implemented as defined in items 1 through 7 for the first year of Trust Fund distribution.***

"(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs. Applications must be received by September 30 of each year for distribution by January 1 of the following year. An application for funds must include the following:

(1) the official name and address of the institution, facility, or program that is applying for funding;
(2) the name, title, and business address of those persons responsible for administering the funds;
(3) the total number, type, and specialty orientation of eligible trainees in each accredited medical education program applying for funds;
(4) audited clinical training costs per trainee for each medical education program;
(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;
(6) other revenue received for the purposes of clinical training;
(7) a statement identifying unfunded costs; and
(8) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds."

For item 8, the only additional information the subcommittee recommends collecting at this time is documentation of program accreditation, the name of the accrediting body, and a complete description of the accounting methodology used to audit the costs being reported

in the application. After the first year of distribution, the requirements may be revisited to determine if adequate information was collected or if additional supporting information is necessary.

Recommendation 7: ***The 1996 MERC legislation regarding the annual cost and program report requirements (see Subd. 2, Section e below) should be implemented as defined in items 1 through 5 for the first year of Trust Fund distribution. For item 6, the only additional information the subcommittee recommends collecting at this time is a description of the allocation process used to distribute the money to the programs, including specific amounts designated for each program for which funding was granted from the Trust Fund. After the first year of distribution, the requirements may be revisited to determine if adequate information was actually collected or if additional supporting information is necessary. The appropriate reporting level for these reports is the sponsoring institution. This reporting allows for a coordinated report from all programs within that institution and designates a centralized point of accountability.***

"(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports based on criteria established by the commissioner. The reports must include:

(1) the total number of eligible trainees in the program;
(2) the type of programs and residencies funded;
(3) the average cost per trainee and a detailed breakdown of the components of those costs;
(4) other state or federal appropriations received for the purposes of clinical training;
(5) other revenue received for the purposes of clinical training; and
(6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training. The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year."

These recommendations are discussed more fully in the two sections of this report titled, "Revenue/Financing Subcommittee Report to the Commissioner" and "Eligibility/Reporting Subcommittee Report to the Commissioner." Those sections, as mentioned previously, also detail the rationale behind the recommendations presented in this report.

Medical Education and Research Costs (MERC) Study Recommendations and Project Progress (1993-1996)

Introduction

The Medical Education and Research Costs (MERC) Advisory Task Force was created in 1993 and since that time work has progressed on developing a preliminary estimate of the costs of medical education in Minnesota. That estimate indicated that supplementary funding is necessary to partially replace patient care dollars being lost due to the increased competitiveness of the health care marketplace. Teaching institutions may not be able to compete effectively while covering the costs of medical education and research. The 1996 Minnesota Legislature established a Medical Education and Research Trust Fund to provide financial assistance specifically targeted for medical education and research. The legislation also required the MERC Advisory Task Force to make recommendations on how the Trust Fund would be financed and on the mechanism used to distribute the funds. (1996 Minn. Laws 451; see Appendix A). Existing legislation also requires that a progress report be submitted to the legislature by February 15 of each year. This report meets both of those requirements.

The organization of this report is as follows: This introduction is followed by a summary of legislative history and project progress (1993-1996) and a summary of the anticipated work plan for 1997. Two MERC subcommittee reports to the Commissioner of Health follow the 1997 work plan discussion: one on revenue/financing and one on eligibility/reporting. The report ends with a short summary of the report recommendations.

Summary of Legislative History and Project Progress (1993-1996)

1993

The Minnesota Legislature passed legislation requiring the Department of Health to study issues related to the financing of medical education and research. The legislature recognized that these two activities benefit not only all health care stakeholders, but society at large as well. Therefore, it was also determined that the cost of medical education and research should not be borne by only a few hospitals or medical centers, but should be fairly allocated across the health care system (Minn. Stat. § 62J.045 [1993]).[2] To address these concerns, the Commissioner of Health established the MERC Advisory Task Force to provide assistance to the commissioner in identifying the issues and to begin development of a plan for estimating the costs of these activities. The original charge given to the commissioner could not be completed before the following legislative session, and a recommendation for continued study

[2] All legislation referenced in this section is included in Appendix A of this report.

was presented to the legislature in the March 1994 report titled, "Future Funding for Medical Education and Research in Minnesota: A Report to the Legislature and Recommendations for Continued Study." The legislature accepted the recommendation, and the MERC Advisory Task Force began their second year of work.

1994

The MERC Advisory Task Force continued to examine the issues associated with medical education and research. It became clear that the complexity involved in the project would prohibit making quick progress. The Task Force established standard definitions and broad guiding principles to be used in developing policy recommendations. An overview of the health professional workforce was also provided along with an analysis of the problems associated with trying to manage such a workforce. This information was presented in a March 1995 report titled, "Medical Education and Research Costs (MERC) In Minnesota's Reformed Health Care System: An Interim Report from the Commissioner of Health to the Legislature." Additional time was requested and granted (1995 Minn. Laws 625) to continue work on developing recommendations for the future financing of medical education and research in Minnesota.

1995

The MERC Advisory Task Force developed a preliminary estimate of the cost of medical education in Minnesota. An attempt was made to also estimate the cost of health care research, but that project could not be completed due to a lack of adequate data. It was decided to focus on the medical education costs and revenues first, and then return to the task of estimating costs for health care research at a later time.

Estimating the costs of medical education proved to be a difficult project. The teaching institutions often did not track their data in ways that were conducive to easy estimation. Consequently, the data had to be collected or estimated in a variety of ways. The cost estimates are thus considered to be only a preliminary estimate. The MERC Advisory Task Force is still seeking to refine the methodology for estimating these costs in order to provide a more precise estimate in the future on an ongoing basis.

A research subcommittee developed a template for estimating total research revenues in Minnesota. However, data gathered was incomplete and provided insufficient information to be useful. Consequently, although health care research is of vital importance to new discoveries in the field of medicine and medical technology and has a significant impact on the state economy, no major funding recommendations for research were included in the February 1996 report to the legislature. The primary research recommendation was to continue the work already begun.

A number of specific recommendations were made to the legislature in the February 1996 report titled, "Medical Education and Research Costs (MERC): A final report to the Legislature." Those recommendations included: (1) establishment of a Medical Education and Research Trust Fund; (2) creation of a Medical Education and Research Cost (MERC)

Advisory Commission; (3) establishment of a financing mechanism; (4) transfer of existing medical education funds (e.g. medical assistance program contributions) to the medical education Trust Fund account; (5) development and implementation of reporting requirements; (6) continued work on health care research; (7) continued refinement of standard care requirement; and (8) establishment of a voluntary pooled research initiative. An adjunct recommendation was also made to increase funding for population–based research.

In response to the recommendations given in the report, the 1996 legislature established a "trust fund for the purposes of funding medical education and research activities in the state of Minnesota." Additionally, the Commissioner of Health was given the authority to appoint an "advisory committee" by January 1, 1997. Application requirements, distribution criteria, and reporting requirements were specified in the legislation (1996 Minn. Laws 451). Also included in this 1996 legislation was a mandate for a "MERC Study." This study was intended to solicit recommendations "on potential sources of funding for medical education and research and on mechanisms for the distribution of such funding sources" (1996 Minn. Laws 451). Thus, while the Trust Fund was formally established, it was not funded. The study would provide more information to legislators on the most appropriate funding source or sources for the Trust Fund.

1996

The MERC Advisory Task Force transitioned to the MERC Advisory Committee (see Appendix B for membership) and added several new members representing a broader range of stakeholders than the original MERC Advisory Task Force had encompassed. The Advisory Committee created two subcommittees to work on the issues assigned in the MERC Study. The Revenue/Financing Subcommittee evaluated a number of financing options and provided recommendations to the commissioner on the most appropriate funding source for the Medical Education and Research Trust Fund. The Eligibility/Reporting Subcommittee reviewed existing legislation regarding the mechanisms for distribution (which included the Trust Fund application, grant distribution, and reporting processes). This subcommittee also provided specific recommendations to the commissioner. Those recommendations are the primary subject of this report and are presented in the Executive Summary. A more detailed discussion is included in the sections titled, "Medical Education and Research Cost (MERC) Revenue/Financing Subcommittee Report," and "Medical Education and Research Cost (MERC) Eligibility/Reporting Subcommittee Report."

In addition to the activities listed above, the MERC Advisory Committee also formed a Research Subcommittee. The Research Subcommittee has begun to again review the requirements for data collection for estimating the cost of health care research in Minnesota. The subcommittee has met twice and is in the process of developing a work plan for the coming year. As with medical education, there are many issues and problems that complicate the process of collecting cost and revenue data. The subcommittee will begin identifying the various issues and problems and then work on the development of an appropriate methodology.

The MERC Advisory Committee, at the direction of the Commissioner of Health, also has been attempting to monitor the impact of the merger of the University of Minnesota Hospital with the Fairview Health System on medical education and research. Both the University and the Fairview Health System have been cooperative in providing as much information as is available. Further, Dr. Frank Cerra, Provost of the University of Minnesota Academic Health Center, and Mr. Richard Norling, President and Chief Executive Officer for the Fairview Health System, met with the MERC Advisory Committee in November 1996 to provide an update on the progress of the merger and to answer specific questions pertaining to its impact on medical education.

Anticipated Work Plan for 1997

It is anticipated that one or more funding sources will be designated for the Medical Education and Research Trust Fund. Contingent upon available funding, the MERC Advisory Committee will continue to refine the Medical Education and Research Trust Fund application, distribution, and reporting processes. They will also further consider how to refine the cost estimation methodology for medical education. The MERC Advisory Committee will continue to examine the issues and problems associated with cost estimation for health care research and will work toward developing a preliminary estimate. They will also continue to monitor the University/Fairview merger and its impact on medical education and research in Minnesota.

Medical Education and Research Cost (MERC) Revenue/Financing Subcommittee Report to the Commissioner of Health

The Revenue/Financing Subcommittee was given the following charge:

"Given that many of the potential sources of financing for medical education are diminishing or being eliminated entirely, new sources of financing must be considered. This subcommittee shall investigate, develop and recommend to the MERC Advisory Committee a specific strategy for providing alternative funding for this critical function. Recommendations to the Advisory Committee may include more than one revenue source.

Some of the relevant issues for the subcommittee to address include:

- Is the revenue source appropriate and broad-based?
- Are the self-insured plans included? How?
- What is the rationale and support for the choice of this funding mechanism?
- What is the expected legislative response?
- Is the revenue source adequate and stable?"

In February 1996 the Department of Health submitted a report titled, "Medical Education and Research Costs (MERC): A final report to the Legislature" to the Minnesota Legislature. After review of the recommendations and options for funding which were presented in the report, the legislature authorized the creation of a "Medical Education and Research Trust Fund" and mandated the "MERC Study" (see Appendix A). This legislation requires the Advisory Committee ("Advisory Task Force" is actual wording) to make specific recommendations to the Commissioner of Health "on potential sources of funding for medical education and research..."

The MERC Advisory Task Force considered a number of options for financing the unfunded costs of clinical training. Those options were as follows:

- General Fund
- Health Care Access Fund
- Additional 1% Tax on HMOs and Non-Profit Organizations
- Voluntary Contributions from Self-Insured Groups

In addition to these potential sources listed, the Revenue/Financing Subcommittee also considered an increase in the alcohol tax and tobacco tax.

It was also suggested in the 1996 MERC report that the Department of Human Services (DHS) might funnel their "add-on" to the Pre-Paid Medical Assistance Program (PMAP) rates to the Trust Fund for distribution. This "add-on" is a small amount added to each of the rate cells used to determine the appropriate capitation rate for Medical Assistance clients who are enrolled in managed care. DHS is in the process of revamping its payment system and is now in the position to be able to pull out that portion of money designated for medical education. Rather than reinventing the wheel in designing a fair payment distribution methodology, DHS has expressed interest in simply directing these funds to the Medical Education and Research Trust Fund. It is anticipated that directing this PMAP "add-on" to the Trust Fund will result in fewer administrative costs as well as the potential for better targeting of scarce funds. ***It is important to note, however, that these dollars from PMAP are not new dollars going to medical education.*** Rather, they are dollars that can be used more effectively and efficiently by consolidating them with the Trust Fund dollars.

Each of these options were carefully reviewed. In the process, assistance was received from the Department of Revenue. After the discussions with the Department of Revenue, it was determined that the alcohol tax was not feasible due to the great percentage increase required to fund the anticipated $10 million for the first year of the Trust Fund. Increasing the tobacco tax was also determined to be an inappropriate choice for ***fully*** funding the Trust Fund, although it could be used as a ***supplementary*** source of funds. This could be accomplished by either raising the current cigarette tax (and dedicating those funds to medical

education) or by dedicating some of the revenue raised from current collections to go to the Trust Fund rather than to the General Fund. A major principle adopted by the MERC Advisory Task Force was to seek a primary funding source which is broad-based and stable. Neither an alcohol or tobacco tax fit that requirement.

Attempting to add an additional 1% tax on the gross premium revenues of HMOs and non-profit organizations was shown to be an extremely volatile option and would likely generate tremendous opposition. This is due to the stated position of the HMOs and non-profit organizations that they are already contributing their "fair share." Because other options were ultimately considered to be better sources anyway, this option was dropped.

Voluntary contributions from self-insured groups was also considered to be unnecessary if funding comes from the General Fund (because of its broad base of contributors). If funding comes from a source other than the General Fund, voluntary contributions could be used as a supplement to that funding source.

Although the Health Care Access Fund (HCAF) is currently showing a large surplus of funds, it was rejected as a primary source of funding the Trust Fund because it is a less broad-based funding source than is the General Fund. Further, while there is a precedent for using the HCAF for medical education, the *major* source of funding for medical education historically has been the General Fund.

The second major objection to use of the HCAF is the diversion of these resources from providing care to the uninsured. While about 20 percent of the revenue in the HCAF is used for administrative and other health care reform projects such as rural health initiatives and health professional scholarships, these uses should be minimized. The best use of the fund is for its primary purpose, providing care for those without access to employer or other government health care programs.

Other objections to recommending the HCAF as a source of funding are: (1) the competition for the HCAF funds may be even more fierce than for the General Fund as it was recently highly publicized as having many millions of dollars in surplus; (2) the 2% provider tax (which includes hospitals and surgical centers) is highly controversial and opposed by some who either oppose the tax specifically or health care reform efforts in general in the state; and (3) if the HCAF option were chosen instead of the General Fund, the question of how to gain participation from the self-insured sector of the market becomes an issue. Voluntary contributions from self-insured groups could be utilized to broaden the base of funding to include as many appropriate contributors as possible, but does not *ensure* that all are participating.

For the reasons outlined above, the most appropriate source of funding for the Trust Fund, in the opinion of the MERC Advisory Committee, is the General Fund. ***Please note that the commissioner's recommendation for a primary source of funding for the Trust Fund presented in the Executive Summary and summary of recommendations at the end of the***

report have been modified to include the Health Care Access Fund. However, the recommendation of the Revenue/Financing Subcommittee is as follows:

Recommendation 1: ***The most appropriate, stable, adequate and broad-based source of funding for the Medical Education and Research Trust Fund is the General Fund.***

Rationale: The General Fund is the most desirable option because of its broad base. As discussed in the February 1996 report to the legislature, the income tax (which is collected and placed in the General Fund) "is the most broad-based and equitable tax in the state of Minnesota. It is progressive, with revenue collections being proportional to income in each particular segment of the population (e.g. the group that represents 40 percent of the income provides 40 percent of the income tax revenue). This would also represent the most stable and predictable source of revenue..." (Medical Education and Research Costs [MERC]: A final report to the Legislature, p. 28). Further, the issue of whether self-insured groups are contributing their fair share is avoided--*everyone* is doing their fair share. The revenues are predictable, adequate and relatively stable (although there is some fluctuation of collection rates depending on employment rates). Finally, education (including medical education specifically) has historically been funded out of this fund. It is, in the judgment of this subcommittee, the most appropriate option.

While the subcommittee strongly recommends the General Fund as the funding source for the Trust Fund, it is also recognized that there is tremendous competition for funding from this source. This competition will, in all likelihood, increase given the anticipated federal changes in welfare and other areas. Therefore, it may be more feasible to utilize funding from a number of sources rather than from only one source.

Recommendation 2: ***Direct the medical education "add-on" funds from the Pre-Paid Medical Assistance Program (PMAP) to the Medical Education and Research Trust Fund for distribution.***

Rationale: As discussed previously, it is anticipated that administrative costs may be reduced since only one agency will be involved in the distribution of medical education funds. Further, historically the medical education "add-on" has been included in every rate cell used to determine the appropriate capitation rate, even the ones that are paid to facilities who are not engaged in medical education. Thus, some money being paid for medical education was never used for that purpose. Although this certainly was not the majority of the money, it clearly was resulting in an inequitable distribution of medical education funds. DHS believes that the methodology being developed by the Department of Health is equitable and appropriate for the distribution of the PMAP medical education dollars, and they are currently working on estimates of the amount that should be transferred to the Trust Fund. At this point in time, the estimate is $15 million for calendar year 1996. That amount will vary each year as the number of PMAP clients increases (due to the anticipated expansion of PMAP to the entire state). Still, it is important to remember that these are not *new* dollars for medical education, but are dollars that will only be redistributed in a more equitable manner.

Medical Education and Research Cost (MERC) Eligibility/Reporting Subcommittee Report to the Commissioner of Health

The Eligibility/Reporting Subcommittee of MERC was given the following charge:

"Based on 1996 legislation, the MERC Advisory Committee is required to assist the Commissioner of Health in the development of Medical Education and Research Trust Fund application process based on specific criteria for eligibility, specification of a formula for distribution of Trust Fund money, and development of reporting requirements.

Some of the relevant issues for the subcommittee to address include:

- Identification and definition of eligibility criteria;
- Revision/finalization of a draft formula for distribution of funding;
- Identification and definition of information to be collected to determine eligibility for funding;
- Identification and definition of information to be collected for required annual cost and program reporting;
- Can the information/data asked for be collected in a standard format?
- What is the most efficient method of collection of this information/data?
- Are there any data privacy issues that need to be addressed?"

The subcommittee began their work by prioritizing the tasks to be completed based on legislative report deadlines. The first four items given in the charge above were determined to be those which needed immediate attention due to the relatively short timeline involved for completing the "MERC Study" mandated by the 1996 legislature. Other items will continue to be discussed.

The administration of a Medical Education and Research Trust Fund is a complex task with many facets--eligibility criteria, distribution methodology, disbursement process, and reporting requirements. It is the goal of the MERC Advisory Committee to establish the basic foundations for the Trust Fund in such a way as to be equitable, efficient, and administratively simple. For that reason, the discussions, and resulting decisions, are focused on the fundamental elements required for each task. In other words, the recommendations included in this report to the MERC Advisory Committee are intended to be as simple as possible in this start-up phase of the Trust Fund project. Further refinements and/or expansion of these basic elements will be implemented on an ongoing basis as the need is defined.

Definitions: The following definitions apply to the recommendations presented in this report.

1) **Sponsoring Institution** - A "sponsoring institution" may be a hospital, school, or consortium that supports teaching programs. These sponsoring institutions typically provide funding and accounting for the programs.

2) **Program** - An eligible teaching "program" is one that is accredited, enrolls trainees, and is responsible for the trainee's overall education. The education may occur at one or more different sites.

3) **Site** - A "site" may be a clinic, hospital or other location where clinical training occurs and training costs are incurred.

4) **Provider Type** - "Provider type" refers to the specific providers eligible under the definition of "Medical education" in the MERC legislation (1996 Minn. Laws, Chapter 451, Article 4, Section 1). That definition currently lists "physicians (medical students and residents), dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants."

Identification and Definition of Eligibility Criteria: The eligibility criteria discussion focused primarily on the questions of how to fund not only current programs, but how to include those programs that are new. However, it was also important to the subcommittee that there not be an incentive, based only on motives of financial gain, that would lead to the creation of new, and perhaps unnecessary, programs. The following recommendation was the result of the ensuing discussion.

Recommendation 1: ***All programs for which application is being made to the Medical Education and Research Trust Fund must already be accredited by an appropriate accreditation body at the time of application.***

Rationale: This recommendation was deliberately kept simple for a number of reasons. First, it is the opinion of the subcommittee that the accreditation bodies for these various programs carry the responsibility for determining the quality of any given program, and assigning its accreditation status. It is not the desire of the subcommittee to second guess their determinations, or to establish any *new* layers of accreditation related only to MERC. Second, to limit programs to being fully accredited might inhibit new programs (which may only receive a provisional accreditation at first) from eligibility. Third, it was agreed by subcommittee members that the current financial incentive involved in this Trust Fund is not sufficient to encourage the creation of a new program for only financial reasons.

Revision/Finalization of a Draft Formula for Distribution of Funding: The distribution of funds is a critical part of the development of the Medical Education and Research Trust Fund. The basic parameters of that formula are defined in the 1996 legislation as follows:

"(d) the commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total trainees in each eligible education program; and (3) the statewide average cost per trainee, by category of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources." (1996 Minn. Laws, Chapter 451, Article 4, Subd. 2)

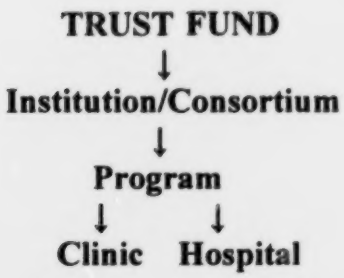
Discussion centered on whether any other incentives should be included beyond these basic parameters (for example, for primary care or other programs identified by the state as "priority need" areas). The conclusion of the subcommittee follows:

Recommendation 2: ***The legislation cited in the previous section regarding the formula for distribution should be implemented as written without further incentives or factors being added at this point in time. The basic formula then becomes the average clinical cost per trainee (by provider type), multiplied by the number of trainees in each program, multiplied by a uniform percentage of costs with total disbursement equaling the amount available for education in the Trust Fund for that year.***

Rationale: The subcommittee was in agreement that the legislative language includes the most basic elements necessary for an equitable distribution of funds. Other factors or incentives may be determined to be either necessary or desirable at a later date. It is the consensus of the subcommittee that implementing a simple formula, and building on that as we have better data and legislative direction is the most practical and logical option. As the Office of Rural Health and Primary Care completes their workforce assessments, specific workforce needs may be identified and documented. Adjustments to the formula may then be incorporated to provide an incentive to those areas of need if that is determined to be appropriate, or for other factors that may be identified in the future.

Recommendation 3: ***Funding from the Medical Education and Research Trust Fund should be directed to the sponsoring institution or consortium responsible for the accredited program(s). The dollars will then be used to support the designated programs and affiliated sites.***

The diagram on the next page illustrates the recommended structure for distribution of money from the Trust Fund. Sponsoring institutions/consortia receive the funds and then use them to support the program designated in the application. Those funds may be used at any number of sites. These sites will most often include, but are not limited to, hospitals and clinics.



↓ **Represents flow of dollars**

Rationale: In some cases, the programs are not prepared to handle funding directly, but rely on the sponsoring institution or consortium for those functions. Further, it reduces the administrative complexity involved if more than one program at a given institution is receiving funding because the application and reporting process can be coordinated at a higher level. However, it is a concern of the subcommittee that the funding received by the sponsoring institutions or consortia is actually transferred to the designated programs and their affiliated sites. The subcommittee is recommending, therefore, that annual cost and program reports include information to document that the programs did in fact receive the funding. That recommendation is discussed further later in this report in the section on annual cost and program reports.

Identification and Definition of Information to Be Collected to Determine Eligibility for Funding: This task is focused on the application requirements for funding from the Trust Fund. As already mentioned in the first item discussed, the program for which funds are being requested must be accredited. Further requirements for the application process are again defined in existing legislation.

> "(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs. Applications must be received by September 30 of each year for distribution by January 1 of the following year. An application for funds must include the following:
>
> > (1) the official name and address of the institution, facility, or program that is applying for funding;
> > (2) the name, title, and business address of those persons responsible for administering the funds;
> > (3) the total number, category, and specialty orientation of eligible trainees in each accredited medical education program applying for funds;
> > (4) audited clinical training costs per trainee for each medical education program;
> > (5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;
> > (6) other revenue received for the purposed of clinical training;
> > (7) a statement identifying unfunded costs; and

(8) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds."

(1996 Minn. Laws 451, Article 4, Subd. 2)

Recommendation 4: ***The legislation cited in the previous section regarding the application requirements should be implemented as defined in items 1 through 7 for the first year of Trust Fund distribution. For item 8, the only additional information the subcommittee recommends collecting at this time is documentation of program accreditation, the name of the accrediting body, and a complete description of the accounting methodology used to audit the costs being reported in the application. After the first year of distribution, the requirements may be revisited to determine if adequate information was actually collected or if additional supporting information is necessary.***

Rationale: Again, a primary consideration in the subcommittee's recommendation was simplicity. There is already a base of information being specifically mandated by the legislation. This is, as with the distribution mandate, considered by the subcommittee to be adequate at this time, with the addition of the accreditation and audit methodology information. The accreditation information is necessary to document that the programs are indeed accredited at the time of application and, further, that they are accredited by an appropriate accrediting body. The rationale for including the audit methodology is discussed in the note below. These requirements may be revised in the future should a need be identified.

Note: A major point of discussion for this item was what the term "audited" costs means in the legislation as it is currently written. The term "audited" costs in this context may have two meanings. The first refers to a standardized reporting format for costs that every Trust Fund applicant must use in reporting costs. The second refers to the use of a standard accounting method for reporting costs, but not requiring that every applicant use the *same* methodology. Because the legislation is vague, it appears that there is some discretion for the Commissioner of Health to make that decision. Therefore, the subcommittee recommends, due to the difficulty of collecting data in a standardized format, that the second definition be adopted in reporting costs. That is the reason for the inclusion of the requirement for a description of the audit methodology in the recommendation. As with other aspects of the reporting requirements, this may be changed if the possibility of standardized reporting ever becomes a reality.

<u>Identification and Definition of Information to Be Collected for Required Annual Cost and Program Reporting</u>: Current legislation also defines the basic parameters for the information to be reported in the annual cost and program reports. It is as follows:

"(e) Medical education programs receiving funds from the trust fund must submit annual costs and program reports based on criteria established by the commissioner.

The reports must include:

(1) the total number of eligible trainees in the program;
(2) the type of programs and residencies funded;
(3) the average cost per trainee and a detailed breakdown of the components of those costs;
(4) other state and federal appropriations received for the purposes of clinical training;
(5) other revenue received for the purposes of clinical training; and
(6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training."

(1996 Minn. Laws 451, Article 4, Subd. 2)

Recommendation 5: ***The legislation cited in the previous section regarding the annual cost and program report requirements should be implemented as defined in items 1 through 5 for the first year of Trust Fund distribution. For item 6, the only additional information the subcommittee recommends collecting at this time is a description of the allocation process used to distribute the money to the programs, including specific amounts designated for each program for which funding was granted from the Trust Fund. After the first year of distribution, the requirements may be revisited to determine if adequate information was actually collected or if additional supporting information is necessary. The appropriate reporting level for these reports is the sponsoring institution. This reporting allows for a coordinated report from all programs within that institution and designates a centralized point of accountability.***

Rationale: There are, as with some other aspects of this project, some basic requirements already defined in legislation for the annual cost and program reports. While the subcommittee is in agreement that these requirements are appropriate, there is also a recognition that it is extremely important for the legislators and the public to be assured that the funding is being used as designated. To allay any fear of misuse of funding, it is important that the allocation process and amounts be clearly identified.

Recommendations

The following recommendations for a funding source and mechanisms of distribution are presented by the Commissioner of Health for consideration in response to the MERC Study mandated under 1996 Minn. Laws 451.

Recommendations on Potential Funding Sources:

Recommendation 1: ***The MERC Trust Fund should be financed by a combination of General Fund and Health Care Access Fund dollars.***[3]

Recommendation 2: ***Direct the medical education "add-on" funds from the Pre-Paid Medical Assistance Program (PMAP) to the Medical Education and Research Trust Fund for distribution.***

Recommendations on Mechanisms for Distribution:

Recommendation 3: ***All programs for which application is being made to the Medical Education and Research Trust Fund must already be accredited by an appropriate accreditation body at the time of application.***

Recommendation 4: ***The 1996 MERC legislation (see Appendix A, 1996 Minn. Laws 451, Subd. 2) regarding the formula for distribution should be implemented as written without further incentives or factors being added at this point in time. The basic formula then becomes the average clinical cost per trainee (by provider type), multiplied by the number of trainees in each program, multiplied by a uniform percentage of costs with total disbursement equaling the amount available for education in the Trust Fund for that year.***

Recommendation 5: ***Funding from the Medical Education and Research Trust Fund should be directed to the sponsoring institution or consortium responsible for the accredited program(s). The dollars will then be used to support the designated programs and affiliated sites.***

Recommendation 6: ***The 1996 MERC legislation (see Appendix A; 1996 Minn. Laws 451, Subd. 2) regarding the application requirements should be implemented as defined in items 1 through 7 for the first year of Trust Fund distribution. For item 8, the only additional information the subcommittee recommends collecting at this time is documentation of program accreditation, the name of the accrediting body, and a complete description of the accounting methodology used to audit the costs being reported in the***

---

[3]The MERC Advisory Committee recommended to the Commissioner of Health that the most appropriate, stable, adequate and broad-based source of primary funding for the Medical Education and Research Trust Fund is the General Fund.

application. After the first year of distribution, the requirements may be revisited to determine if adequate information was actually collected or if additional supporting information is necessary.

Recommendation 7: *The 1996 MERC legislation (see Appendix A, 1996 Minn. Laws 451, Subd. 2) regarding the annual cost and program report requirements should be implemented as defined in items 1 through 5 for the first year of Trust Fund distribution. For item 6, the only additional information the subcommittee recommends collecting at this time is a description of the allocation process used to distribute the money to the programs, including specific amounts designated for each program for which funding was granted from the Trust Fund. After the first year of distribution, the requirements may be revisited to determine if adequate information was actually collected or if additional supporting information is necessary. The appropriate reporting level for these reports is the sponsoring institution. This reporting allows for a coordinated report from all programs within that institution and designates a centralized point of accountability.*

APPENDIX A

Medical Education and Research Cost (MERC) Legislation
Minn. Stat. § 62J.045 (1993)

ARTICLE 3

Section 5. **MEDICAL EDUCATION AND RESEARCH COSTS.**

Subdivision 1. **PURPOSE.** The legislature finds that all health care stakeholders, as well as society at large, benefit from medical education and health care research. The legislature further finds that the cost of medical education and research should not be borne by a few hospitals or medical centers but should be fairly allocated across the health care system.

Subd. 2. **DEFINITION.** For purposes of this section, "health care research" means research that is not subsidized from private grants, donations, or other outside research sources but is funded by patient out-of-pocket expenses or a third party payer and has been approved by an institutional review board certified by the United States Department of Health and Human Services.

Subd. 3. **COST ALLOCATION FOR EDUCATION AND RESEARCH.**
By January 1, 1994, the commissioner of health, in consultation with the health care commission and the health technology advisory committee, shall:

(1) develop mechanisms to gather data and to identify the annual cost of medical education and research conducted by hospitals, medical centers, or health maintenance organizations;

(2) determine a percentage of the annual rate of growth established under section 62J.04 to be allocated for the cost of education and research and develop a method to assess the percentage from each group purchaser;

(3) develop mechanisms to collect the assessment from group purchasers to be deposited in a separate education and research fund; and

(4) develop a method to allocate the education and research fund to specific health care providers.

APPENDIX A (Continued)

Medical Education and Research Costs (MERC) Legislation
1994 Minn. Laws 625

ARTICLE 5

Section 10. **CONTINUED STUDY OF MEDICAL EDUCATION AND RESEARCH COSTS.**

Subdivision 1. **PURPOSE.** The legislature finds that health care research and the preparation of future health care practitioners are of great importance to the quality of health care available to the citizens of this state; that medical education and research must be designed to meet the health needs of the population and the changing needs of the health care delivery system; and that the cost of medical education and research should not place institutions engaged in these activities at a competitive disadvantage in the marketplace.

Subd. 2. **SCOPE OF STUDY.** The commissioner of health shall continue the study developed as part of Minnesota Statutes, section 62J.045, on the impact of state health care reform on the financing of medical education and research activities in the state. The study shall address issues related to the institutions engaged in these activities, including hospitals, medical centers, and health plan companies, and will report on the need for alternative funding mechanisms for medical education and research activities. The commissioner shall monitor ongoing public and private sector activities related to the study of the financing of medical education and research activities and include a description of these activities in the final report as applicable. The commissioner shall submit a report on the study findings, including recommendations on mechanisms to finance medical education and research activities, to the legislature by February 15, 1995.

Subd. 3. **RECOMMENDATIONS.** The study shall explore both private and public alternatives for funding medical education and research activities. The study shall include recommendations which, when implemented, would:

(1) help to assure the coordination between federal and state funding mechanisms;

(2) help assure adequate funding to support medical education and research activities;

(3) create alternative funding mechanisms, if necessary, to assure that medical education and research are responsive to the health needs of the population and the needs of Minnesota's health delivery system;

(4) help to assure that any changes in funding for medical education and health care research do not destabilize institutions that currently conduct, sponsor, or otherwise engage in health care research and medical education; and

(5) allocate the costs of medical education and research fairly across the health care system.

Subd. 4. **TASK FORCE.** The commissioner may appoint an advisory task force to provide expertise and advice on the study. The task force may include up to 20 members. The commissioner shall take under consideration representation of the following groups: the Minnesota association of public teaching hospitals and other nonteaching hospitals; private academic medical centers; the University of Minnesota medical school and its primary care

residency programs; payer organizations including managed care, nonprofit health service plan organizations, and commercial carriers; other providers including the Minnesota medical association, the Minnesota nurses association, and others; a representative of the health technology advisory committee; employers; consumers; and medical researchers. The task force shall include representation of rural areas in the state.

APPENDIX A (Continued)

Medical Education and Research Costs (MERC) Legislation
1995 Minn. Laws 625

ARTICLE 5

Section 10. **CONTINUED STUDY OF MEDICAL EDUCATION AND RESEARCH COSTS.** *(Only Subd. 2 amended.)*

Subdivision 1. **PURPOSE.** The legislature finds that health care research and the preparation of future health care practitioners are of great importance to the quality of health care available to the citizens of this state; that medical education and research must be designed to meet the health needs of the population and the changing needs of the health care delivery system; and that the cost of medical education and research should not place institutions engaged in these activities at a competitive disadvantage in the marketplace.

Subd. 2. **SCOPE OF STUDY.** The commissioner of health shall continue the study developed as part of Minnesota Statutes, section 62J.045, on the impact of state health care reform on the financing of medical education and research activities in the state. The study shall address issues related to the institutions engaged in these activities, including hospitals, medical centers, and health plan companies, and will report on the need for alternative funding mechanisms for medical education and research activities. The commissioner shall monitor ongoing public and private sector activities related to the study of the financing of medical education and research activities and include a description of these activities in the final report as applicable. The commissioner shall submit a report on the study findings, including recommendations on mechanisms to finance medical education and research activities, to the legislature by February 15, 1996.

Subd. 3. **RECOMMENDATIONS.** The study shall explore both private and public alternatives for funding medical education and research activities. The study shall include recommendations which, when implemented, would:

(1) help to assure the coordination between federal and state funding mechanisms;

(2) help assure adequate funding to support medical education and research activities;

(3) create alternative funding mechanisms, if necessary, to assure that medical education and research are responsive to the health needs of the population and the needs of Minnesota's health delivery system;

(4) help to assure that any changes in funding for medical education and health care research do not destabilize institutions that currently conduct, sponsor, or otherwise engage in health care research and medical education; and

(5) allocate the costs of medical education and research fairly across the health care system.

Subd. 4. **TASK FORCE.** The commissioner may appoint an advisory task force to provide expertise and advice on the study. The task force may include up to 20 members. The commissioner shall take under consideration representation of the following groups: the Minnesota association of public teaching hospitals and other nonteaching hospitals; private academic medical centers; the University of Minnesota medical school and its primary care

residency programs; payer organizations including managed care, nonprofit health service plan organizations, and commercial carriers; other providers including the Minnesota medical association, the Minnesota nurses association, and others; a representative of the health technology advisory committee; employers; consumers; and medical researchers. The task force shall include representation of rural areas in the state.

APPENDIX A (Continued)

Medical Education and Research Costs (MERC) Legislation
1996 Minn. Laws 451

ARTICLE 4

Section 65. **[MERC STUDY.]**
The medical education and research cost advisory task force shall make recommendations to the commissioner of health and to the house health and human services committee and both finance divisions, and the senate health care committee and the senate health care and family services finance division by December 15, 1996, on potential sources of funding for medical education and research and on mechanisms for the distribution of such funding sources.

APPENDIX A (Continued)

Medical Education and Research Costs (MERC) Legislation
1996 Minn. Laws 451

ARTICLE 4

Section 1. **[MEDICAL EDUCATION AND RESEARCH TRUST FUND.]**

Subdivision 1. **[DEFINITIONS.]** For purposes of this section, the following definitions apply:

(a) "Medical education" means the accredited clinical training of physicians (medical students and residents), dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training that occurs in both inpatient and ambulatory care settings.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out-of-pocket expenses or a third-party payer.

(e) "Commissioner" means the commissioner of health.

(f) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

Subd. 2. **[ALLOCATION AND FUNDING FOR MEDICAL EDUCATION AND RESEARCH.]**

(a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall:

(1) consider the interest of all stakeholders when selecting committee members;

(2) select members that represent both urban and rural interest; and

(3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by Minnesota Statutes, section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs. Applications must be received by September 30 of each year for distribution by January 1 of the following year. An application for funds must include the following:

(1) the official name and address of the institution, facility, or program that is applying for funding;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) the total number, type, and specialty orientation of eligible trainees in each accredited medical education program applying for funds;

(4) audited clinical training costs per trainee for each medical education program;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;

(6) other revenue received for the purposes of clinical training;

(7) a statement identifying unfunded costs; and

(8) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria:

(1) total medical education funds available;

(2) total trainees in each eligible education program; and

(3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports based on criteria established by the commissioner. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the type of programs and residencies funded;

(3) the average cost per trainee and a detailed breakdown of the components of those costs;

(4) other state or federal appropriations received for the purposes of clinical training;

(5) other revenue received for the purposes of clinical training; and

(6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training. The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the department of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the trust fund.

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

APPENDIX B

1996 Department of Health
MERC ADVISORY COMMITTEE MEMBERS

James Toscano, Chair, HealthSystem Minnesota
John Abenstein, Mayo Clinic
Peter Benner, AFSCME
Byron Crouse, University of Minnesota School of Medicine
James Davis, St. Cloud Hospital
Sandra Edwardson, University of Minnesota School of Nursing
Thomas Elliott, Duluth Clinic
Ronald Franks, University of Minnesota School of Medicine
William Goodall, Allina Health System
David Herman, Mayo Clinic
William Jacott, University of Minnesota Medical School
Jim Kohrt, Cargill Corporation
Louis Ling, Hennepin County Medical Center
Gregg McPherson, 3M Center
Kathleen Meyerle, Mayo Clinic
Robert Mulhausen, HealthPartners Institute
Eric Netteberg, MidAmerica Life Insurance Company
Frank Nuttall, VA Medical Center
Delwin Ohrt, Blue Cross Blue Shield of Minnesota
Robert Petzel, VA Medical Center
Marilyn Speedie, University of Minnesota College of Pharmacy
Pamela Tibbetts, Fairview/Riverside Medical Center
Michael Till, University of Minnesota School of Dentistry
Catherine Wisner, Group Health Foundation

To obtain additional copies of this report,
please contact:

Minnesota Department of Health
Minnesota Health Information Clearinghouse
121 East 7th Place, P.O. Box 64975
St. Paul, Minnesota 55164-0975
(612) 282-6314; (800) 657-3793

BEST COPY AVAILABLE

Minnesota Department of Health
Health Economics Program
121 East Seventh Place, P.O. Box 64975
St. Paul, Minnesota 55164-0975
(612) 282-6356

Printed with a minimum of 10% post-consumer materials. Please recycle.

Upon request, this information will be made available in alternative format; for example, large print, Braille, or cassette tape.

BEST COPY AVAILABLE